

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  535026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/07/2024
NAME OF PROVIDER OR SUPPLIER  Big Horn Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1851 Big Horn Ave Sheridan, WY 82801	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</b></p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure acceptable parameters of nutritional status for 2 of 5 sample residents (#5, #6) reviewed for nutrition. The findings were:</p> <ol style="list-style-type: none"> <li>1. Review of the annual MDS assessment dated [DATE] showed resident #5 had short-term and long-term memory problems and diagnoses which included chronic kidney disease stage 3, non-Alzheimer's dementia, anxiety disorder, depression, muscle wasting and atrophy, and dysphagia. Further review showed the resident had weight loss greater than 5 percent and required supervision or touching assistance with eating. The following concerns were identified:               <ol style="list-style-type: none"> <li>a. Review of the resident's weight history showed s/he weighed 148 pounds on 5/22/24 and 120.3 pounds on 11/6/24, a weight loss of 18.71 percent.</li> <li>b. Review of the meal intake record from 10/9/24 through 11/7/24 showed the resident did not have a recorded meal intake for 16 out of 88 meals, was marked response not required was marked for 15 out of 88 meals, ate 0 to 25 percent for 5 out of 88 meals, and ate 26 percent to 50 percent for 10 of 88 meals. Further review showed on 10/24 there was no record of dinner, on 10/25 there were no recorded meals, and on 10/26 there was no record for breakfast and lunch was recorded as 0 to 25 percent.</li> <li>c. Interview with the dietitian on 11/7/24 at 9:46 AM revealed the resident will sleep through meals and the facility has to work with staff to encourage residents to get up. She revealed if the resident was up more often, his/her nutrition would improve. Further interview revealed the resident body mass index was below where she would like him/her to be.</li> </ol> </li> <li>2. Review of the annual MDS assessment dated [DATE] showed resident #6 had short-term and long-term memory problems and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, depression, and muscle wasting and atrophy. Further review showed the resident had weight loss greater than 5 percent and required partial/moderate assistance with eating. The following concerns were identified:               <ol style="list-style-type: none"> <li>a. Review of the resident's weight history showed s/he weighed 103 pounds on 5/6/24 and 91 pounds on 10/1/24, a weight loss of 11.65 percent.</li> </ol> </li> </ol> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Review of the meal intake record from 10/8/24 through 11/6/24 showed the resident did not have a recorded meal intake for 12 out of 87 meals, was marked response not required for 13 out 87 meals, ate 0 to 25 percent for 3 out of 87 meals, and ate 26 percent to 50 percent for 5 out of 87 meals.</p> <p>c. Interview with the dietitian on 11/7/24 at 9:46 AM confirmed the resident had a decline and revealed staff needed to ensure s/he was assisted up to the dining room. Further interview confirmed the resident's body mass index was below where she would like it to be.</p> <p>3. Interview with staff member #1 on 11/6/24 at 12:52 PM revealed a lack of staff had resulted in weight loss for residents. The staff member indicated staff were not able to assist residents to the dining room or provide assistance with meals.</p> <p>4. Interview with the DON, administrator, and regional nurse on 11/7/24 at 12:08 PM revealed they were unsure why the residents were marked response not required and revealed the system should trigger an alarm if they did not receive a meal. Further interview revealed if a resident refused meals or did not eat their meal, staff should offer an alternative and snacks.</p> <p>5. Review of the policy titled Meal Supervision and Assistance provided by the facility on 11/7/24 showed .</p> <p>15. If the resident refuses to eat offer alternative items/meal choice, inform the supervisor of continued refusal .17. Encourage the resident to participate with his or her meal as much as possible. When indicated, provide special devices (i.e., two-handed and/or covered cups, hand holder utensils, dishes secured with suction cups, etc.) which will increase independence and participation with meals. 18. Continue feeding until the resident has had enough food or until the meal is finished .20. If the resident wishes to eat later, or cannot eat now, communicate the resident's wishes to your supervisor and other staff members caring for the resident and set a more appropriate time for the resident to receive the meal .</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>35081</p> <p>Based on medical record review, and staff interviews, and review of the staff schedule, the facility failed to ensure sufficient nursing staff was provided on 1 of 4 units (Courtyard) reviewed for medication administration. The findings were:</p> <ol style="list-style-type: none"> <li>1. Review of resident #7's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of finasteride 5 milligrams (mg) related to benign prostatic hyperplasia with lower urinary tract symptoms, fluoxetine 10 mg related to depression, tamsulosin 0.4 mg related to benign prostatic hyperplasia with lower urinary tract symptoms, and protonix 40 mg related to gastrointestinal hemorrhage, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for losartan 100 mg, apply moisturizing lotion, and triamcinolone acetonide external cream 0.1% at 6 AM.</li> <li>2. Review of resident #8's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of cyanocobalamin 1000 micrograms (mcg) related to supplementation, metformin 1000 mg related to type II diabetes mellitus, multiple vitamins tablet related to supplementation, vitamin D3 capsule 25 mcg related to supplementation, acetaminophen 650 mg related to pain and pacing, losartan 50 mg related to hypertension (hold for blood pressure less than 100/60), and Risperdal 1 mg related to dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance at 6 am.</li> <li>3. Review of resident #9's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of dextansoprazole 60 mg related to gastro-esophageal reflux disease, Zoloft 50 mg related to major depression, divalproex sodium 250 mg related to unspecified dementia, unspecified severity, with other behavioral disturbance, midodrine 5 mg related to orthostatic hypotension, and Seroquel 100 mg related to degeneration of the brain, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for acidophilus probiotic related to cellulitis of the left lower limb, aloe vera capsule related to urinary health, aspirin 81 mg related to prophylaxis, d-mannose 500 mg related to urinary health, MiraLAX 17 grams (gm) related to fecal impaction/constipation at 6 AM, nutritional snacks at 10 AM and 3 PM, Seroquel 100 mg at 11 AM, and midodrine 5 mg at 12 PM.</li> <li>4. Review of resident #10's medication administration record for October 2024 showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for glycolax powder 17 gm related to constipation, meloxicam 15 mg related to bilateral primary osteoarthritis of the knee, multivitamin-minerals related to supplementation, levetiracetam 500 mg related to seizures, sennosides 8.6 mg related to constipation, Tylenol 650 mg related to pain, at 6 AM, Tylenol 650 mg at 11 AM, haloperidol 2 mg related to schizophrenia at 6 AM and 11 AM, and nutritional supplements at 9 AM and 2 PM.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Review of resident #11's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of amlodipine 10 mg related to hypertension, donepezil 5 mg related to unspecified dementia without behavioral disturbance, lisinopril 5 mg related to hypertension (hold if blood pressure less than 100/60), meloxicam 7.5 mg related to low back pain, MiraLAX powder 17 gm related to constipation management, and Tylenol 1000 mg related to low back pain, at 6 AM.</p> <p>6. Review of resident #12's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of calcium-vitamin d 600 mg-220 mg related to vitamin D deficiency and docusate sodium 100 mg related to constipation, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for urea external cream 40% related to keratosis at 6 AM and oral nutritional supplement at 2 PM.</p> <p>7. Review of resident #13's medication administration record for October 2024 showed the resident had a hold order on 10/10/24, which was signed off by the administrator, metoprolol 25 mg related to chronic diastolic heart failure (hold if blood pressure is less than 100/60), polyethylene glycol 17 gm related to bowel health, quetiapine 50 mg related to vascular dementia with behavioral disturbance, sertraline 100 mg related to anxiety disorder, and acetaminophen 1000 mg related to pain, at 6 AM, sennoside-docusate 8.8 mg-50 mg related to bowel management and spironolactone 25 mg related to edema at 8 AM, acetaminophen 1000 mg at 11 AM, and trazadone 50 mg related to unspecified vascular dementia, unspecified severity, with other behavioral disturbance, at 12 PM.</p> <p>8. Review resident #14's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of folic acid 1 mg related to supplementation, levothyroxine 75 mcg related to drug-induced thyroiditis, potassium chloride 20 milliequivalent (mEq) related to hypokalemia, tamsulosin 0.4 mg related to benign prostatic hyperplasia, thiamine 100 mg related to supplementation, and pantoprazole 40 mg related to gastro-esophageal reflux disease, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for Tums 500 mg related to heartburn, probiotic, at 6 AM, and the 9 AM and 11 AM snacks.</p> <p>9. Review of the staff schedule dated 10/10/24 showed no nurse or MA-C was scheduled for the 6 AM to 6:30 PM shift in the courtyard unit.</p> <p>10. Interview with CNA #1 on 11/6/24 at 2 PM revealed the staff member was moved to the courtyard unit on 10/10/24 due to someone being ill and not being available to work. The CNA revealed there was not a staff member passing medications to residents that day and another CNA came to the unit at 8 AM.</p> <p>11. Interview with CNA #2 on 11/6/24 at 2:16 PM revealed she replaced CNA #1 on 10/10/24 because they did not have anyone to work Courtyard.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12. Interview with MA-C #1 on 11/6/24 at 2:23 PM revealed when she left on 10/10/24 she was told to give the keys to the Courtyard medication cart to MA-C #1 until the former DON came in. MA-C #2 was assigned to the Rock Creek unit and the only staff member on the Courtyard unit was a CNA. When MA-C #1 returned later that day for her next shift, there continued to be only a CNA on the Courtyard unit. The MA-C revealed the CNA told her no medications had been administered to the residents on the unit and MA-C #1 would need to administer the missed medications. At that time, MA-C #1 notified the administrator and regional operations director, the medications had not been administered. The MA-C revealed she was told it was a serious medication error and they would need to notify the regional clinical director. The MA-C revealed the residents in the Courtyard unit were pacing and some had elevated blood pressures and she attempted to keep them calm. Further interview revealed that when she reviewed the residents' notes they indicated medications had been held due to provider orders.</p> <p>13. Interview with the former DON on 11/6/24 at 2:35 PM revealed on 10/10/24 he was the only nurse in the building. He stated if he remembered right, he did the morning medications. He revealed he tried to help out but was probably caught up somewhere else or probably kept getting pulled away.</p> <p>14. Interview with MA-C #2 on 11/7/24 at 12:10 PM revealed she was asked to work on the Rock Creek unit on 10/10/24 and when she learned there was nobody scheduled for the Courtyard unit, she said she could not do both units. The MA-C revealed she gave the Courtyard unit medication cart keys to the former DON at 8 AM. She revealed she told the former DON she had not administered any medications to residents on the unit. At 11 AM, she was notified by the CNA on the Courtyard unit, of resident behaviors and the CNA needed help. The MA-C went to the unit to try and calm residents. The MA-C revealed the residents were yelling and screaming, threatening others, seemed unsettled, and were getting worked up. The MA-C revealed the behaviors seemed normal for the residents when they had not received their medications. At that time, the CNA reported the residents had not received any medications that day and the former DON had not been on the unit.</p> <p>15. Interview with the administrator on 11/6/24 at 2:43 PM revealed on 10/10/24, MA-C #1 reported none of the medications were administered to residents on the Courtyard unit. The administrator revealed the former DON was assigned to administer the medications and said he forgot. The administrator revealed the former DON said he had not administered any medications to residents on the Courtyard unit that day. She revealed the scheduling that day was supposed to be a CNA in Courtyard and the former DON was to be available.</p> <p>16. Interview with nurse practitioner #1 and the administrator on 11/7/24 at 8:56 AM confirmed the staff members scheduled on Courtyard between 6 AM and 6:30 PM were not able to administer medications.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>35081</p> <p>Based on medical record review and staff interview, the facility failed to ensure medical records were accurately documented for 6 of 8 sample residents (#7, #8, #9, #11, #12, #14) reviewed for significant medication errors. The findings were:</p> <ol style="list-style-type: none"> <li>1. Review of resident #7's medication administration record for October 2024 showed 10/10/24 the former DON signed off administration of finasteride 5 milligrams (mg) related to benign prostatic hyperplasia with lower urinary tract symptoms, fluoxetine 10 mg related to depression, tamsulosin 0.4 mg related to benign prostatic hyperplasia with lower urinary tract symptoms, and protonix 40 mg related to gastrointestinal hemorrhage, at 6 AM.</li> <li>2. Review of resident #8's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of cyanocobalamin 1000 micrograms (mcg) related to supplementation, metformin 1000 mg related to type II diabetes mellitus, multiple vitamins tablet related to supplementation, vitamin D3 capsule 25 mcg related to supplementation, acetaminophen 650 mg related to pain and pacing, losartan 50 mg related to hypertension (hold for blood pressure less than 100/60), and Risperdal 1 mg related to dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance at 6 AM.</li> <li>3. Review of resident #9's medication administration record for October 2024 showed 10/10/24 the former DON signed off administration of dexlansoprazole 60 mg related to gastro-esophageal reflux disease, Zoloft 50 mg related to major depression, divalproex sodium 250 mg related to unspecified dementia, unspecified severity, with other behavioral disturbance, midodrine 5 mg related to orthostatic hypotension, and Seroquel 100 mg related to degeneration of the brain, at 6 AM.</li> <li>4. Review of resident #11's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of amlodipine 10 mg related to hypertension, donepezil 5 mg related to unspecified dementia without behavioral disturbance, lisinopril 5 mg related to hypertension (hold if blood pressure less than 100/60), meloxicam 7.5 mg related to low back pain, MiraLAX powder 17 gm related to constipation management, and Tylenol 1000 mg related to low back pain, at 6 AM.</li> <li>5. Review of resident #12's medication administration record for October 2024 showed the former DON signed off administration of calcium-vitamin d 600 mg-220 mg related to vitamin D deficiency and docusate sodium 100 mg related to constipation, at 6 AM.</li> <li>6. Review resident #14's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of folic acid 1 mg related to supplementation, levothyroxine 75 mcg related to drug-induced thyroiditis, potassium chloride 20 milliequivalent (mEq) related to hypokalemia, tamsulosin 0.4 mg related to benign prostatic hyperplasia, thiamine 100 mg related to supplementation, and pantoprazole 40 mg related to gastro-esophageal reflux disease, at 6 AM</li> <li>7. Interview with CNA #1 on 11/6/24 at 2 PM revealed on 10/10/24 there was not a staff member passing medications to residents that day.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. Interview with MA-C #1 on 11/6/24 at 2:23 PM revealed when she left on 10/10/24 she was told to give the keys to courtyard medication cart to MA-C #2 until the former DON came in. MA-C #2 was assigned to the rock creek unit and the only staff member on the courtyard unit was a CNA. When MA-C #1 returned later that day, there continued to be only a CNA on the Courtyard unit. The MA-C revealed the CNA told her no medications had been administered to the residents on the unit and MA-C #1 would need to administer the missed medications. At that time, MA-C #1 notified the administrator and regional operations director the medications had not been administered. The MA-C revealed she was told it was a serious medication error and they would need to notify the regional clinical director. The MA-C revealed the residents in the courtyard unit were pacing and some had elevated blood pressures and she attempted to keep them calm. Further interview revealed when she reviewed the residents' notes they indicated medications had been held due to provider orders.</p> <p>9. Interview with the former DON on 11/6/24 at 2:35 PM revealed on 10/10/24 he was the only nurse in the building. He stated if he remembered right, he did the morning medications. He revealed he tried to help out but was probably caught up somewhere else or probably kept getting pulled away.</p> <p>10. Interview with MA-C #2 on 11/7/24 at 12:10 PM revealed on she was asked to work on the Rock Creek unit on 10/10/24 and when she learned there was nobody scheduled for the Courtyard unit, she said she could not do both units. The MA-C revealed she gave the Courtyard unit medication cart keys to the former DON at 8 AM. She revealed she told the former DON she had not administered any medications to residents on the unit. At 11 AM, she was notified by the CNA on the Courtyard unit, of resident behaviors and the CNA needed help. The MA-C went to the unit to try and calm residents. The MA-C revealed the residents were yelling and screaming, threatening others, seemed unsettled, and were getting worked up. The MA-C revealed the behaviors seemed normal for the residents when they had not received their medications. At that time, the CNA reported the residents had not received any medications that day and the former DON had not been on the unit.</p> <p>11. Interview with the administrator on 11/6/24 at 2:43 PM revealed on 10/10/24, MA-C #1 reported none of the medications were administered to residents on the Courtyard unit. The administrator revealed the former DON was assigned to administer the medications and said he forgot. The administrator revealed the former DON said he had not administered any medications to residents on the courtyard unit that day and she was unsure why the medications were signed off.</p> <p>12. Interview with nurse practitioner #1 and the administrator on 11/7/24 at 8:56 AM revealed when the administrator spoke to the former DON following the incident on 10/10/24, he was unable to explain why the medications were not administered. They confirmed the other staff members scheduled on Courtyard between 6 AM and 6:30 PM were not able to administer medications.</p>		